PennState Health
Milton S. Hershey Medical Center

Patient Name: VARGAS, JUSTINO MRN 2318020

ED Summary

RESULT STATUS: Final
DOCUMENT SUBJECT: GI bleeding
ELECTRONICALLY SIGNED BY: Brea,MD,Isabel J (12/8/2014 14:04 EST); Khazalpour,MD, Michael K (12/2/2014 18:00 EST)

GI bleeding

Patient: **VARGAS, JUSTINO** **MRN: 2318020**
Age: **68 years** Sex: **Male** DOB Redacted
Associated Diagnoses: **None**
Author: **Khazalpour, MD, Michael K**

Basic Information

Time seen: Immediately upon arrival.
History source: Patient.
Arrival mode: Private vehicle.
History limitation: None.
Additional information: Chief Complaint from Nursing Triage Note : Visit Reason
12/2/2014 05:21 Visit reason Blood in Stool
.

History of Present Illness

The patient presents with rectal bleeding. The onset was 2 hours ago. The course/duration of symptoms is constant. Vomiting: bright red and degree moderate. Rectal bleed: grossly bloody. Risk factors consist of nonsteroidal anti-inflammatory drugs and prior diverticulosis bleeding 8 years ago. Prior episodes: rare. Associated symptoms: dizziness, denies abdominal pain, denies nausea, denies vomiting and denies diarrhea. Additional history:

Patient is a 68-year-old male who presents for evaluation of bright red blood per rectum Patient states he is visiting his family from Florida and had a bowel movement approximately 2 hours ago when he almost passed out on the toilet, and required help from his wife and his sons to help him of the toilet. Wife noticed large amounts of bright red blood in the toilet bowl. Patient felt weak and dizzy. Family brought him to HMC ED for evaluation. PMHx of hypertension, prediabetes and arthritis as well as a history of diverticular bleed years 8 ago that required coagulation on colonoscopy.

Review of Systems

Constitutional symptoms: No fever, no chills, no sweats, no weakness, no fatigue, no decreased activity.
Skin symptoms: No rash,
Eye symptoms: Vision unchanged, No recent vision problems,
Respiratory symptoms: No shortness of breath,
Cardiovascular symptoms: No chest pain,
Gastrointestinal symptoms: Abdominal pain, rectal bleeding.
Genitourinary symptoms: Dysuria.
Musculoskeletal symptoms: No back pain,
Neurologic symptoms: No headache,
Hematologic/Lymphatic symptoms: Bleeding tendency negative, bruising tendency negative.
Allergy/immunologic symptoms: No recurrent infections,
Additional review of systems information: All other systems reviewed and otherwise negative.

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Patient Name: VARGAS, JUSTINO MRN 2318020

ED Summary

Health Status

Allergies:

Allergic Reactions (Selected)

No Known Medication Allergies

.

Past Medical/ Family/ Social History

Medical history

Cardiovascular: hypertension.
Endocrine negative.
Surgical history: Colonoscopy.
Family history: Not significant.
Social history: Alcohol use: Denies, Tobacco use: Denies, Drug use: Denies, Occupation: Retired, Family/social situation: Married.

Physical Examination

Vital Signs

Vital Signs

12/2/2014 06:30	Heart Rate	81 bpm
	Respiratory Rate	16 br/min
	Systolic Blood Pressure	133 mmHg
	Diastolic Blood Pressure	72 mmHg
	Mean Blood Pressure	94 mmHg
	Cuff Pulse Pressure	61 mmHg
	SpO2	98 %
12/2/2014 06:15	Heart Rate	79 bpm
	Respiratory Rate	11 br/min
	SpO2	97 %
12/2/2014 06:00	Heart Rate	79 bpm
	Respiratory Rate	12 br/min
	Systolic Blood Pressure	110 mmHg
	Diastolic Blood Pressure	62 mmHg
	Mean Blood Pressure	80 mmHg
	Cuff Pulse Pressure	48 mmHg
	SpO2	96 %
	Monitor Rhythm	Normal sinus rhythm
12/2/2014 05:50	Heart Rate	87 bpm
	Respiratory Rate	13 br/min
	Systolic Blood Pressure	107 mmHg
	Diastolic Blood Pressure	55 mmHg
	Mean Blood Pressure	73 mmHg
	Cuff Pulse Pressure	52 mmHg
	SpO2	95 %
12/2/2014 05:45	Heart Rate	96 bpm

ED Summary

	Respiratory Rate	16 br/min
	Systolic Blood Pressure	64 mmHg
	Diastolic Blood Pressure	49 mmHg
	Mean Blood Pressure	55 mmHg
	Cuff Pulse Pressure	15 mmHg
	SpO2	99 %
12/2/2014 05:30	Heart Rate	96 bpm
	Respiratory Rate	22 br/min
	Systolic Blood Pressure	74 mmHg
	Diastolic Blood Pressure	49 mmHg
	Mean Blood Pressure	65 mmHg
	Cuff Pulse Pressure	25 mmHg
	SpO2	91 %
12/2/2014 05:21	**Temperature**	**35.5 DegC LOW**
	Temperature Route	Oral
	Heart Rate	105 bpm
	Respiratory Rate	16 br/min
	Systolic Blood Pressure	87 mmHg
	Diastolic Blood Pressure	61 mmHg
	BP Location # 1	Left Arm
	SpO2	98 % .

General: Alert, moderate distress, ill-appearing, diaphoretic hypotension, tachycardia, pale, .
Skin: Dry, normal for ethnicity, cool, pale, clammy
Head: Atraumatic.
Neck: Supple, trachea midline, no JVD.
Eye: Extraocular movements are intact, vision unchanged
Ears, nose, mouth and throat: Oral mucosa moist, no pharyngeal erythema or exudate.
Cardiovascular: Regular rate and rhythm, Normal peripheral perfusion.
Respiratory: Lungs are clear to auscultation, respirations are non-labored, breath sounds are equal, Symmetrical chest wall expansion.
Chest wall: No tenderness, No deformity.
Back: Nontender, Normal range of motion, Normal alignment.
Musculoskeletal: Normal ROM, normal strength, no tenderness, no swelling, no deformity.
Gastrointestinal: Soft, abdominal distention, Obese, Tenderness: Negative, suprapubic, Guarding: Negative, Rebound: Negative, Bowel sounds: Normal, Trauma: Negative, Signs: None.
Neurological: Alert and oriented to person, place, time, and situation, No focal neurological deficit observed, normal sensory observed, normal motor observed, normal speech observed, normal coordination observed.
Lymphatics: No lymphadenopathy.
Psychiatric: Cooperative, appropriate mood & affect, normal judgment.

Medical Decision Making

Differential Diagnosis: GI bleed, diverticulosis vs. diverticulitis bleeding.
Rationale: Patient presents with bright red bleeding from his rectum. We will obtain 2x large bore IV access type across 2 units of blood, obtain a CBC CMP abdominal CT initiate IV Protonix and requested mission to

internal medicine service for further evaluation and treatment of his acute GI bleed most likely related to his extensive NSAID use.

Documents reviewed: no emergency department records no prior records.

Cardiac monitor: Normal sinus rhythm.

Results review: Lab results : Laboratory

12/2/2014 05:45	Request of Physician	pt/inr
	Action Taken	Test ADDED
12/2/2014 05:41	Sodium	139 mmol/L
	Potassium	4.5 mmol/L
	Chloride	107 mmol/L
	HCO3	**20 mmol/L LOW**
	Anion Gap	12 mmol/L
	BUN	**53 mg/dL HI**
	Creatinine	**2.02 mg/dL HI**
	Estimated GFR, Black Race	**40 mL/min/1.73 m2 LOW**
	Estimated GFR, non-Black Race	**33 mL/min/1.73 m2 LOW**
	Glucose	**339 mg/dL HI**
	Calcium	8.9 mg/dL
	WBC Count	**18.86 K/uL HI**
	Hemoglobin	**10.7 g/dL LOW**
	Hematocrit	**32.3 % LOW**
	RBC Count	**3.65 M/uL LOW**
	MCV	88.5 fL
	MCHC	33.1 g/dL
	MCH	29.3 pg
	RDW	14.1 %
	Platelet Count	288 K/uL
	MPV	10.8 fL
	Type of Diff:	AUTO
	Immature Gran%	1.2 %
	Neut%	69.8 %
	Lymph%	23.4 %
	Mono%	5.1 %
	Baso%	0.1 %
	Eos%	0.4 %
	Immat Gran, Abs	0.22 K/uL
	Neut, Abs	**13.10 K/uL HI**
	Lymph, Abs	**4.38 K/uL HI**
	Mono, Abs	0.95 K/uL
	Baso, Abs	0.02 K/uL
	Eos, Abs	0.07 K/uL
	Protime	**15.3 seconds HI**
	Protime INR	**1.22 HI**
	ALT	29 unit/L
	Bilirubin, Total	0.5 mg/dL
	Alkaline Phosphatase	52 unit/L

ED Summary

	AST	34 unit/L
	Albumin	**3.2 g/dL LOW**
	Total Protein	**5.9 g/dL LOW**
	ABO/Rh	O POSITIVE
	ABO Recheck	O POSITIVE
	Antibody Screen	NEGATIVE
	Crossmatch Exp	12/05/2014
	Key Transfusion #	NRQ
	Component Type	RED CELLS
	# Units Ordered	2
	Blue	Specimen available from 0 to 3 days based on specimen stability. Please use addon order if you wish to order testing.
12/2/2014 05:31	ABO/Rh	NOT DONE
	Antibody Screen	NOT DONE
	Crossmatch Exp	12/02/2014
	Key Transfusion #	NRQ
	Component Type	RED CELLS
	# Units Ordered	0
	BB Comments	DUPLICATE REQUEST

, Interpretation Abnormal results acute blood loss anemia severely elevated WBC.

Radiology results: Computed tomography, **IMPRESSION:** Extensive colonic diverticulosis without diverticulitis.

Sequela of prior omental infarct in the left lower quadrant.

Reexamination/ Reevaluation

Vital signs

results included from flowsheet : Vital Signs

12/2/2014 07:30	**Temperature**	**36.0 DegC LOW**
	Temperature Route	Oral
	Heart Rate	76 bpm
	Respiratory Rate	13 br/min
	Systolic Blood Pressure	129 mmHg
	Diastolic Blood Pressure	64 mmHg
	BP Location # 1	Left Arm
	Mean Blood Pressure	94 mmHg
	Cuff Pulse Pressure	65 mmHg
	Oxygen Therapy	Room air
	SpO2	98 %

Course: well controlled.

Assessment: exam improved, patient states after 2 L of NS his dizziness and weakness has improved. He is comfortably awaiting admission to the internal medicine service.

Procedure

Procedure notes:

PennState Health
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ED Summary

A total of 55 minutes of critical care time were spent in initial assessment, recurrent reassessments as therapy progressed, discussion with patient, family and consultants at the bedside. Time involved in the performance of separately reportable procedures was not counted toward critical care time. Teaching time is also not included in this total. After aggressive fluid resuscitation patient was hemodynamically stable, will admit fir further management and disposition of rectal bleeding

Impression and Plan

Diagnosis

Gastrointestinal bleed 578.9 (ICD9 578.9)
Rectal bleeding 569.3 (ICD9 569.3)
Gastritis 535.50 (ICD9 535.50)

Diagnosis

Diverticulosis of colon with hemorrhage (ICD9 562.12)

Calls-Consults

- Internal medicine, consult, recommends for admission.

Plan

Condition: Improved, Stable.

Disposition: Admit: To Inpatient Unit, Lotner, MD, Daniel E, not medically cleared

Counseled: Patient, Family, Regarding diagnosis, Regarding diagnostic results, Regarding treatment plan, Regarding prescription, Patient indicated understanding of instructions.

Addendum

Teaching-Supervisory Addendum-Brief

I participated in the following activities of this patients care: the medical history, the physical exam, medical decision making, the procedure.
I personally performed: supervision of the patient's care, the medical history, the physical exam, the medical decision making.
The case was discussed with: the resident.
Procedures: I performed the procedure.
Evaluation and management service: I agree with the evaluation and management decisions made in this patient's care.
Results interpretation: I agree with the study interpretation in this patient's care.

Signatures:

,
.

Electronic Signature on File

Electronically Reviewed/Signed by: Michael K Khazalpour, MD Author Signature Dt/Tm:12/02/2014 06:00 PM

Electronically Reviewed/Signed by: Isabel J Brea, MDCosigner Signature Dt/Tm: 12/08/2014 02:04 PM

MKK DD: 12/02/14

PennState Health
Milton S. Hershey Medical Center

Penn State Hershey Tel: (717) 531-8055
Milton S. Hershey Medical Center
Health Information Services, HU24
500 University Drive
P.O. Box 850
Hershey, PA 17033-0850

Patient Name: VARGAS, JUSTINO
MRN: 2318020
Date of Birth: Redacted
Patient Gender: Male

Visit Number: 21891441
Visit Type: Inpatient
Patient Location: 2EA3; 2044; 1

Discharge Summary

RESULT STATUS: Final
DOCUMENT SUBJECT: .D/C Summary
ELECTRONICALLY SIGNED BY: Lotner,MD,Daniel E (12/3/2014 15:38 EST)

DISCHARGE SUMMARY

Name: VARGAS, JUSTINO
HMC Number: 2318020
DOB Redacted
Date of Admission: 12/02/2014
Date of Discharge: 12/03/2014

Physician: Lotner, MD, Daniel E

Service: Internal Medicine

Discharge Diagnosis: Acute Blood loss anemia from GI bleed 2/2 Gastric Ulcer from NSAID use
Acute renal failure

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Acute renal failure

Other Diagnoses: HTN
Osteoarthritis left hip
Pre-diabetes
Diverticulosis

Other Diagnoses: HTN
Osteoarthritis left hip
Pre-diabetes
Diverticulosis

Major Procedures and Tests:
EGD and Colonoscopy 12/2/2014

EGD:
Multiple shallow gastric ulcers consistent with NSAID induced gastritis

Colonoscopy:

Discharge Summary

Diverticulosis without evidence of acute bleeding

Vaccinations Received This Hospital Stay:
No vaccinations were given this hospital stay.

Discharge Medications:
1. Pantoprazole (Protonix 40 mg oral delayed release tablet) 40 mg (1 tab) by mouth 2 times daily.
2. Tramadol (traMADol 50 mg oral tablet) 50 mg (1 tab) by mouth every 4 hours, as needed for pain.
3. Hydrochlorothiazide-losartan (hydrochlorothiazide-losartan 25 mg-100 mg oral tablet) 1 tab by mouth once daily.
4. Amlodipine .

Brief History of Present Illness:
HISTORY OF PRESENT ILLNESS: Mr. Vargas is a 68-year-old gentleman with a past medical history of diverticulosis diagnosed in 2008, status post apparent endoscopic cauterization who presented to the emergency department this morning with complaints of 2 episodes of bleeding per rectum. The patient reports that last night he had "upset stomach" which he attributed to having eaten cheese steak in Philadelphia the night before, although upon moving his bowels, he noticed maroon-colored blood on the toilet paper. At that point, he reports that he moved his bowels again. At that time the patient reports that the blood was not only on the toilet paper, but was in the toilet bowl, it was less formed and was described as being bright red "almost clear". At that point, the patient started to feel lightheadedness and a faint feeling and increased sweating. The patient says that is when they called the ambulance to bring him to Hershey Medical Center.

The patient also reports that he has had hip pain for the last week for which he took Aleve over-the-counter 2 to 3 times per day, but was then given Naprosyn by his doctor and for the last 5 days, he has been taking Naprosyn every 6 hours. His last dose was at 11:30 p.m. last night. The patient denies any abdominal pain, nausea, vomiting, fevers or chills, although does admit to increased sweating and a feeling of lightheadedness.

ED COURSE: Upon admission, the patient's hemoglobin was found to be 10.7 with a white blood cell count of 18.9, likely due to dehydration versus true leukocytosis. He was afebrile, tachycardic with a heart rate of 105 and blood pressure in the 60s/40s. He was then given 2 liters of normal saline and his heart rate decreased to 76 and blood pressure rose to 129/64. After his course of saline the patient reports that he felt less lightheaded. A CT scan was performed, which showed diverticulosis, but not diverticulitis and GI was consulted.

Hospital Course:
The pt was admitted to the Internal Medicine service in guarded condition with IMC status and treated for the following:
1) Acute blood loss anemia - the pt presented with BRBPR. Upon admission he was tachycardic and hypotensive. He was therefore admitted to the IMC for close observation. He was aggressively resuscitate with IVF with normalization of his vital signs. GI was consulted and immediately took him for and EGD and Colon. He was found to have gastric ulcers and 2 of them had recent eschars. This is most likely induced by his recent heavy NSAID use. His colonoscopy was positive for diverticular disease. The pt had no further hematochezia or melena following the procedures. His H/H was trended and remained stable. At no time did he require a transfusion. The pt had a flight to catch the following day and despite our concern for rebleed he insisted on leaving. He was medically discharged and did not leave AMA. He was instructed to avoid all NSAID use and was started on high dose Ppis. He fully understands the urgency to return to any ED if he has any further bleeding or melena or sx of anemia.
2) AKI - Due to his anemia, dehydration, and hypotension. He was aggressively hydrated with improvement of his kidney function.
3) Gap acidosis - resolved with the addition of IVF
4) PreDM - the pt was instructed to follow up with his PCP

Exam on Discharge:
General: Awake, alert, anxious but oriented to time, place, person in no acute distress.
HEENT: Normocephalic, atraumatic. Pupils are equally, round, reactive. Mucous membranes are moist. Neck supple, no JVD, no lymphadenopathy. Chest: Clear to auscultation bilaterally.
Cardiac: Regular in rate and rhythm, no murmurs, rubs or gallops.
Abdomen: Obese, soft, nontender to palpation. Bowel sounds are quiet in all 4 quadrants. No hepatosplenomegaly appreciated.
Back: Nontender over the spine. No CVA tenderness.
GU: No lesions, no discharge.
Extremities: Trace lower extremity edema, right slightly greater than left. Pedal pulses 1+ bilaterally. Radial pulses 2+ bilaterally.
Skin: No rashes.
Neuro: Strength and sensation grossly intact

Care Instructions:
****A discharge summary will be sent to your primary care physician to ensure continuity of care. Please bring this discharge summary with you to your next office appointment so that your provider can review it at that time ****

Follow up appointments:

We requested appointment with Dr. Farhad within 1 week of discharge. Please have him do a follow up CBC and BMP.

If you do not have the appointment details (date and time) at the time of discharge, someone from your PCP's office will contact you. If you do not hear directly from his office within 2-3 business days, please call Dr. Farhad Tel (904) 460 9191 to request an appointment.

Medications:

AVOID all NSAIDs (Ibuprofen, Naproxen, Aleve)

Please discuss alternatives for your arthritis with your PCP. For now you can take Tylenol and Tramadol.

NEW MEDICATIONS: Please take Protonix 40mg twice daily for the next one month to help the ulcers heal

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PennState Health
Milton S. Hershey Medical Center

Patient Name: VARGAS, JUSTINO MRN 2318020

Discharge Summary

Please discuss alternatives for your arthritis with your PCP. For now you can take Tylenol and Tramadol.

NEW MEDICATIONS: Please take Protonix 40mg twice daily for the next one month to help the ulcers heal

Diet Guidelines:
Please eat a regular and healthy diabetic/cardiac friendly diet. This includes a diet rich in vegetable and fruits, whole grain, high fiber foods, lean meat and poultry, fish, and fat-free or one percent fat dairy products. Your diet should be low in sugars, carbohydrates, saturated fat, trans fat, and cholesterol.

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Activity Guidelines:
Please resume your previous home activities slowly as tolerated. Always take fall precautions and ask for assistance as you regain your strength and endurance.

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Please resume your previous home activities slowly as tolerated. Always take fall precautions and ask for assistance as you regain your strength and endurance.

Call your doctor if:
Please call your primary care doctor for symptoms including, but not limited to: bloody or black tarry stools, fevers (temperatures >100.4 degrees F or 38.1 degrees Celsius), chills, intractable nausea or vomiting, diarrhea, shortness of breath, or if you experience any worsening of the symptoms that brought you to the hospital.

For **emergency** and **very serious** health related issues such as bright red blood per rectum, vomiting of blood or “coffee ground” vomiting, chest pain, shortness of breath, or sudden onset of the symptoms that brought you to the hospital you may need to call 911 or go directly to the Emergency Room.

Call your doctor if:
Please call your primary care doctor for symptoms including, but not limited to: bloody or black tarry stools, fevers (temperatures >100.4 degrees F or 38.1 degrees Celsius), chills, intractable nausea or vomiting, diarrhea, shortness of breath, or if you experience any worsening of the symptoms that brought you to the hospital.

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Patient Name: VARGAS, JUSTINO MRN 2318020

Discharge Summary

Follow-Up Appointments:

No Follow-Up Appointments have been scheduled.

Electronic Signature on File

Electronically Reviewed/Signed by: Daniel E Lotner, MD Author Signature Dt/Tm:12/03/2014 03:38 PM

DEL /TLD DD: 12/03/14 DT: 12/03/14 15:09

PennState Health
Milton S. Hershey Medical Center

Patient Name: VARGAS, JUSTINO MRN 2318020

H&P

RESULT STATUS: Final
DOCUMENT SUBJECT: History & Physical
ELECTRONICALLY SIGNED BY: Mucha,MD,Simon R (12/2/2014 18:42 EST)

HISTORY & PHYSICAL

Name: VARGAS, JUSTINO
HMC Number: 2318020
DOB: Redacted
Date of Service: 12/02/2014

REASON FOR ADMISSION, CHIEF COMPLAINT: Bright red blood per rectum.

HISTORY OF PRESENT ILLNESS: Mr. Vargas is a pleasant 68-year-old male with hypertension, prediabetes and arthritis as well as a history of diverticular bleed years 8 ago that required coagulation on colonoscopy, who is currently visiting with family from Florida. He was recently started on standing naproxen 500 mg p.o. b.i.d. approximately 1 week ago for left hip osteoarthritis and has been doing reasonably well without acute complaints until at 1:00 a.m. last night when he noted "grumbling in his belly". He went to the bathroom and had a large bowel movement consisting of bright red blood. He has not experienced any abdominal pain, nausea, vomiting, no other symptoms at the time. When he had a second large bright red bowel movement at 3:00 a.m. and thus dcided to come to the emergency department to seek further evaluation. At presentation, the patient was tachycardic at a rate of 105 beats per minute and hypotensive blood pressure of 87/61. The patient was given 2 liters of normal saline with improvement of his blood pressure to 125/70 with heart rate to 77 beats per minute. Initial lab work revealed slight anemia with a hemoglobin of 10, as well as acute renal failure with a creatinine of 2.0 and a lactate of 2.5. Internal Medicine was consulted for admission.

REVIEW OF SYSTEMS: A complete review of systems was negative unless outlined in the HPI and is only significant for left hip pain and mild chronic right greater than left trace lower extremity edema.
In addition, the patient has started complaining of feeling cold and chilly just since arriving at the emergency department.

PAST MEDICAL HISTORY:
1. Hypertension.
2. Left knee arthritis.
3. Prediabetes.
4. Diverticulosis with diverticular bleed 8 years ago.

PCP Dr. Farhad Tel (904) 460 9191 will call and request records

PAST SURGICAL HISTORY:
1. Lumbar fusion in July, 2013.
2. Cholecystectomy.
3. Appendectomy.

FAMILY HISTORY: Negative for bleeding disorders or GI disorders.

SOCIAL HISTORY: The patient does not smoke, does not drink, is a retired New York policeman who is now a preacher in Florida, came here to visit the christening of his great-granddaughter.

H&P

ALLERGIES: None.

CURRENT HOME MEDICATIONS:
1. Amlodipine 10 mg p.o. daily.
2. Losartan/hydrochlorothiazide 10/25.
3. Tramadol 50 mg q. 4 as needed.
4. Naproxen 500 mg p.o. b.i.d.

PHYSICAL EXAMINATION:
Temperature 36.0, heart rate of 77 beats per minute, blood pressure 124/70, respiration 14, saturating 98% on room air. Weight 131 kilograms.
General: Awake, alert, anxious but oriented to time, place, person in no acute distress.
HEENT: Normocephalic, atraumatic. Pupils are equally, round, reactive. Mucous membranes are moist. Neck supple, no JVD, no lymphadenopathy. Chest: Clear to auscultation bilaterally.
Cardiac: Regular in rate and rhythm, no murmurs, rubs or gallops.
Abdomen: Obese, soft, nontender to palpation. Bowel sounds are quiet in all 4 quadrants. No hepatosplenomegaly appreciated.
Back: Nontender over the spine. No CVA tenderness.
Rectal: Dark red blood with no stool on bedside rectal exam.
GU: No lesions, no discharge.
Extremities: Trace lower extremity edema, right slightly greater than left. Pedal pulses 1+ bilaterally. Radial pulses 2+ bilaterally.
Skin: No rashes.
Neuro: Strength and sensation grossly intact.

LABS: Complete blood count: CBC: White cell count of **18.8**, hemoglobin of **10.7**, hematocrit of 32.3 with 13,000 neutrophils, 4000 lymphocytes.
PT INR 15.3 and 1.22.:
Basic metabolic panel: Sodium 139, potassium 4.5, chloride 107, bicarbonate of 20, BUN of 53, creatinine of **2.0**, glucose of 339. Lactate 2.5. VBG: pH 7.31
LFTs within normal limits.
Albumin 3.2.

CT abdomen showed extensive colonic diverticulosis without diverticulitis, sequela of prior omental infarct as well as symmetrically enhancing kidneys with multiple cysts, but no hydronephrosis.

ASSESSMENT AND PLAN: A 68-year-old male with hypertension and prediabetes, recently started on NSAIDs, now presenting with acute blood loss anemia likely secondary to a diverticular bleed less likely upper GI blled, now hemodynamically stabilized after volume resuscitation.

1. Admit to Medicine, IMC status.

2. Acute blood loss anemia. The patient has been typed and crossed. He has 3 peripheral IVs in place, started on IV Protonix. Will hold NSAIDs and continue to trend H/H q 8 hours. Transfuse for goal of Hgb > 7. I expect since he is tachycardic, hypotensive on presentation with acute renal faliure and high lactate that his H/H will drop some more after fluid resuscitation.

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H&P

He has had no bowel movements since arriving in the emergency department, has hemodynamically responded to just 2 liters of normal saline so I hope is is not continuing to actively bleed.
Will continue to fluid resuscitate him with normal saline IV at 100 mL an hour.
GI was consulted for possible EGD and colonoscopy.

3. Acute renal failure, likely multifactorial in the setting of new NSAID use with ACE inhibitors, diuretics, and hypovolemic/anemic hypotension.
Will send urinalysis for white cells, eosinophils, casts as well as urine lytes for FeNa/FeUrea to further evaluate possible AIN or ATN from NSAIDs versus prerenal azotemia.
Will monitor with fluid resuscitation and expect this will improve although he did unfortunately get IV contrast for his abdominal CT.
Will hold all nephrotoxic agents, antihypertensives and diuretics for now.
Monitor I's and O's closely.

4. Gap metabolic acidosis. The patient's bicarb is 20, with a gap of 12, corrects to 14.5 when accounting for his decreased albumin. This is likely due to organ malperfusion due to hypotension as well as acute renal failure. We will continue to monitor and expect to see imrpovement with volume resuscitation.

5. Leukocytosis. Again, likely secondary to acute blood loss anemia and hypotension. I do not see any obvious source of infection based on history and physical as well as his abdominal imaging. The patient was started on IV ciprofloxacin and Flagyl which I we will hold this as we do not have any evidence of diverticulositis.

6. Prediabetes. The patient us hyperglycemic on presentation, will put him on sliding scale n.p.o. and monitor. Will check hemoglobin A1c and treat as necessary.

7. Hip arthritis: tylenol for now no NSAID

8. Fluid, electrolytes and nutrition. NPO, normal saline at 100 and monitor his acidosis, mag and phos with renal failure.

9. Prophylaxis: GI prophylaxis with PPI. No pharmacologic DVT prophylaxis due to acute bleed.

10. Disposition. IMC for close monitoring, possible bedside scope per GI. Downgrade to floor status if H&H remain stable and no recurrent active bleed.
Patient has a return flight to Florida at 2PM tomorrow which he is eager to catch, but anticipate will not be able to make it.

Initial H&P Coding Selection

Low	Moderate	High	
99221	99222	99223	Diagnosis
		xx	Acute hemorrhagic shock 2/2 acute blood loss anemia 2/2 NSAID w divertivular bleed vs PUD, acute renal failure with gap

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Patient Name: VARGAS, JUSTINO MRN 2318020

H&P

			metabolic acidosis, lactic acidosis

#1933665

Electronic Signature on File

Electronically Reviewed/Signed by: Simon R Mucha, MD *Author Signature Dt/Tm:12/02/2014 06:42 PM*

SRM /CB DD: 12/02/14 DT: 12/02/14 12:00

PennState Health
Milton S. Hershey Medical Center

Patient Name: VARGAS, JUSTINO MRN 2318020

Inpatient Note

RESULT STATUS: Final
DOCUMENT SUBJECT:
ELECTRONICALLY SIGNED BY: Dye,MD,Charles E (12/5/2014 08:19 EST); Welch,MD,Amy R (12/3/2014 14:09 EST)

GASTROENTEROLOGY INPATIENT PROGRESS NOTE

Name: VARGAS, JUSTINO
Patient Number: 2318020
DOB Redacted
Date of Service: 12/03/2014

Surgical Hospital Day/Procedure: No procedures found

SUBJECTIVE: _No more bleeding since admission. VSS overnight. Hgb 7.7 this am but all cell counts dropped so likely diultional in setting of IVF for AKI which has improved as well.

OBJECTIVE: _

Vitals: Last Updated 12/03/14 08:00

Date	Temp	Pulse	BP	RR	SpO2	FIO2
12/03 08:00	36.7	88	131/75	16	96	RA
12/03 04:00	36.7	78	141/67	0	97	RA
12/03 00:00	36.6	79	121/55	16	97	RA
12/02 20:00	36.5	105	138/68	14	93	RA
12/02 18:07	36.6	78	149/93	14		RA

24 Hr Tmax: 36.7 at 12/03 08:00

Weights: Last Updated 12/02/14 11:52

Date	Wt(kg)	Wt(lb)
12/02 11:52	131.5	289
12/02 11:52	131.5	289
12/02 05:21	131.5	289
12/02 05:21	131.5	289

Initial Wt: 12/02 131.5 kg 289 lb

	Recorded	Input	Output	Balance
12/02	**7a-3p**	2370	800	1570
	3p-11p	10	0	10
	11p-7a	0	0	0
	24 Total	2380	800	1580
12/01	**7a-3p**	0	0	0
	3p-11p	0	0	0

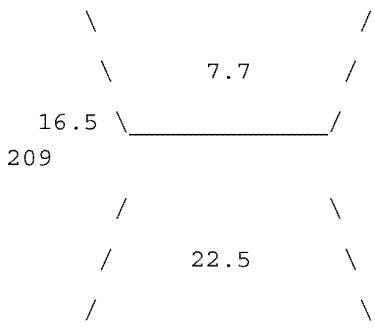
Inpatient Note

11p-7a	1000	0	1000
24 Total	1000	0	1000

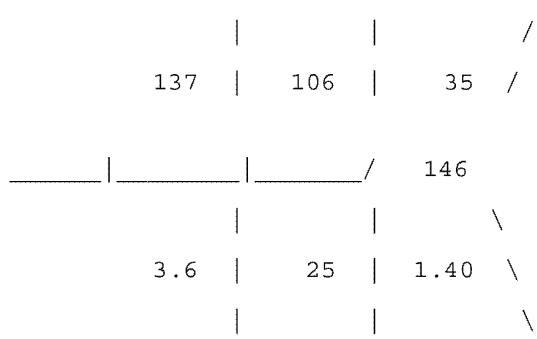
****Refer to the I-VIEW - I&O tab for details**

Most Recent Lab Results over the last 24 Hours:

CBC: on 12/03/2014 04:58



BMP: on 12/03/2014 04:58



Active Inpt Meds:
pantoprazole (Protonix) 40 mg PO bid
Active PRN Meds:
acetaminophen (Tylenol) 650 mg PO q4h
morphine 2 mg IV q6h
oxycodone 5 mg PO q4h
One Time Meds: (Completed)
Sodium Chloride 0.9% (NS Bolus) 1,000 mL w/ IV ONCE(Completed)
Sodium Chloride 0.9% (NS Bolus) 2,000 mL w/ IV ONCE(Completed)
pantoprazole (Protonix) 80 mg w/ IV ONCE(Completed)
polyethylene glycol 3350 with electrolytes (GoLYTELY) 4,000 mL w/ bowel prep ONCE
Active IV Meds: None

ASSESSMENT: _ 68yoM w/ bright red blood per rectum s/p EGD w/ gastric ulcers, likely bleeding source but not active bleeding, colonoscopy with tics and hemorrhoids but no bleeding. Low likelihood for rebleeding.

PLAN: _

1) _BID PPI for 8 weeks

PennState Health
Milton S. Hershey Medical Center

Patient Name: VARGAS, JUSTINO MRN 2318020

Inpatient Note

2) _No need for repeat EGD

3) _ No NSAIDS

If H pylori + needs treatment.

D/W Dr. Dye

Attending staff addendum: Reviewed EGD report and consistent with low likelihood of rebleeding now on therapy and off NSAIDS

Electronic Signature on File

Electronically Reviewed/Signed by: Amy R Welch, MD Author Signature Dt/Tm:12/03/2014 02:09 PM

Electronically Reviewed/Signed by: Charles E Dye, MDCosigner Signature Dt/Tm: 12/05/2014 08:19 AM

ARW DD: 12/03/14

PennState Health
Milton S. Hershey Medical Center

Patient Name: VARGAS, JUSTINO MRN 2318020

Consult

Neuro: No focal deficits. Oriented to person, place and time.

ASSESSMENT: Mr. Vargas is a 68-year-old man with a history of diverticulosis, presenting with acute GI bleed, possibly due to bleeding per diverticula versus PUD associated with recent use of NSAIDs.

RECOMMENDATIONS:
1. Recommend bowel prep to prepare him for an EGD and colonoscopy to be performed later today or tomorrow to assess need for endoscopic therapy and risk/stratify diseases.
2. The patient will be IMC status in case the GI bleeding continues and he needs a bedside colonoscopy/EGD.
3. The patient will benefit from moderate sedation for these procedures to decrease the risks of endoscopy with general anesthesia levels.

The patient was seen, examined and discussed this with the attending consultant, Dr. Dye, who agrees with the above assessment and plan.

Consultation Coding Selection

Min	Brief	Intermediate	Extensive	Comprehensive	Diagnosis
99251	99252	99253	99254	99255	hematochezia, acute blood loss anemia
			x		

#1933584
Attending addendum: I saw and examined the patient and endorsed the above assessment and recommendations- please see any additional associated comments as follows:
- Reviewed CT scan images
- At risk for PUD but also will benefit from colonoscopy given prior history and nature of this bleeding presentation

Electronic Signature on File

Electronically Reviewed/Signed by: Michael Foster, MD Author Signature Dt/Tm:01/04/2015 11:48 AM

Electronically Reviewed/Signed by: Charles E Dye, MDCosigner Signature Dt/Tm: 12/02/2014 08:46 PM

MF /PAS DD: 12/02/14 DT: 12/02/14 11:24

* Final *

PENNSTATE
The Milton S. Hershey Medical Center
The College of Medicine

Name: Vargas, Justino
Birthdate: Redacted
Patient ID: 2318020

Procedure Report **EGD Report**
Date: 12/2/2014 Time: 2:30 PM AMENDED REPORT

CHART COPY

Procedure

Procedure Upper GI endoscopy (EGD), 43235. EGD with biopsy(s): 43239.
Personnel Responsible Endoscopist is Emmanuelle Williams. Procedure performed by Lisa Yoo, DO. Procedure personnel: Endoscopist (Attending physician) - Emmanuelle Williams, Endoscopist (Fellow) - Lisa Yoo, DO, Nurse - Lugene A. McCormick, RN, Nurse - Amber Fine, BSN, RN. The fellow performed the procedure. Attending present for the entire procedure.
Referring provider Simon R. Mucha, MD
Patient consent Consent for the procedure was obtained. Person consenting: Patient. Consent was obtained by: Physician.
Time out Time-out was performed to confirm the identity of the patient and the nature of the procedure.
Procedure details The procedure was completed. Patient position: Left side. Depth of insertion intended: Duodenum. Depth of insertion actually reached: Duodenum. Gastric retroflexion was performed. Images were taken. Biopsy(s) were taken. Water immersion was not utilized. CO2 was used as the insufflation gas. Time from scope insertion to scope removal 7 minutes. Patient tolerance for the procedure was excellent. Estimated blood loss 1 ml.
Fluoroscopy Fluoroscopy was not used.
Instruments Instrument(s) used: GIF-HQ190 (Serial # 445- Flexible Trans-Anal).
Patient disposition After the procedure, the patient was sent remain in endo suite. After recovery, the patient was sent back to hospital.

Indications

Primary indication Evaluation of active/recent bleeding.
Management of GI Blood Loss The procedure was performed for management of GI blood loss as evidenced by: evaluation of active bleeding. Details of active bleeding include: hematochezia.

History

Surgical history The patient has a history of the following surgical procedures: cholecystectomy, appendectomy, . Other surgical history: Lumbar fusion in July 2013.
Medical history The patient has a history of the following medical conditions: hypertension. Other medical history: Diverticulosis, prediabetes, left knee arthritis.
Allergies No known allergies.

Physical Exam

Pre-Procedure Physical Exam Abdominal exam: Normal. Airway exam: Normal. Cardiopulmonary exam: Normal. Extremity exam: Normal.
Comments on Physical Exam Abd: Soft, NT/ND.

Preprocedure

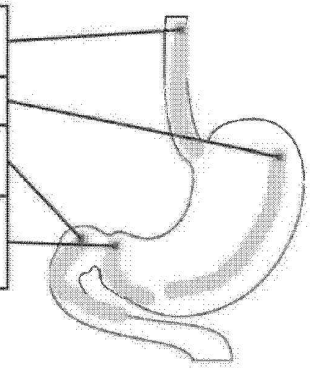
Patient Admission Status Inpatient with endoscopy performed in the Endoscopy suite.

Sedation / Anesthesia

Presedation Assessment ASA classification: III. Urgency: Elective. Assessed by Endoscopist (Attending physician).
Monitoring The patient was monitored by: blood pressure measurements, ECG, pulse oximetry, capnography.
Medications Level of sedation: Moderate (conscious sedation). Sedation was managed by: Endoscopist (Attending physician). Sedation medication(s) administered: midazolam 4 mg IV, fentanyl 50 mcg IV.

EGD Findings

NORMAL: Starting location: Proximal Esophagus. Ending location: Distal Esophagus. Image(s) taken. Comments: Z line at 42cm.
NORMAL: Starting location: Fundus. Ending location: Body. Image(s) taken.
NORMAL: Starting location: Duodenal Bulb. Ending location: Duodenum. Image(s) taken.
ULCER: Location: Antrum. Ulcer stigmata: non-bleeding, clean. Comments: Multiple small clean based ulcers, biospies obtained. Image(s) taken. 4 biopsies taken. Pathology IDs: . Specimen sent to pathology.



Assessment

Assessment

MR ENDO

* Final *

PENNSTATE
The Milton S. Hershey Medical Center
The College of Medicine

Name: Vargas, Justino
Birthdate: Redacted
Patient ID: 2318020

Procedure Report **EGD Report**
Date: 12/2/2014 Time: 2:30 PM AMENDED REPORT

1. Multiple small clean based ulcers, no visible vessels and no active bleed, obtained biopsies
2. Normal duodenum

PLAN:
1. Continue PPI
2. Further management as per inpatient team
3. Repeat EGD in 4-6 weeks to document healing
4. Await biopsy reports, and treat H.Pylori if positive
5. Colonoscopy today

Events / Interventions

Unplanned Events There were no unplanned events or interventions.

Report electronically signed by: Emmanuelle Williams 12/2/2014 5:33:00 PM

* Final *

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The College of Medicine

Name: Vargas, Justino
Birthdate: Redacted
Patient ID: 2318020

Procedure Report **Colonoscopy Report**
Date: 12/2/2014 Time: 2:30 PM

CHART COPY

Procedure

Procedure Colonoscopy: 45378.
Personnel Procedure performed by Lisa Yoo, DO. Responsible Endoscopist is Emmanuelle Williams. Procedure personnel: Endoscopist (Attending physician) - Emmanuelle Williams, Endoscopist (Attending physician) - Thomas J. McGarrity, M.D., Endoscopist (Fellow) - Lisa Yoo, DO. The fellow performed the procedure. Attending present for the entire procedure.
Referring provider Simon R. Mucha, MD
Patient consent Consent for the procedure was obtained. Person consenting: Patient. Consent was obtained by: Physician.
Time out Time-out was performed to confirm the identity of the patient and the nature of the procedure.
Procedure details Water immersion was not utilized. CO2 was used as the insufflation gas. The procedure was completed. Patient position: On left side. Abdominal compression was used. Instrument(s) used: CF-HQ190L (Serial # 005- Flexible Trans-Anal). Retroflexion performed. Biopsy(s) were not taken. Fluoroscopy was not used. Images were taken. Patient tolerance for the procedure was excellent. Estimated blood loss 0 ml.
Prep results Prep results: Excellent - no more than small bits of adherent fecal material.
Depth of insertion Depth of insertion intended: Terminal ileum. Depth of insertion actually reached: Terminal ileum.
Procedure duration Time from scope insertion to scope removal 24 minutes. Withdrawal time 8 minutes.
Patient disposition After the procedure, the patient was sent to recovery. After recovery, the patient was sent back to hospital.

Indications

Primary indication Hematochezia.
Evaluation of GI Blood Loss The procedure was performed for evaluation of GI blood loss as indicated by: hematochezia.

History

Surgical history The patient has a history of the following surgical procedures: cholecystectomy, appendectomy, . Other surgical history: Lumbar fusion in July 2013.
Medical history The patient has a history of the following medical conditions: hypertension. Other medical history: Diverticulosis, prediabetes, left knee arthritis.
Allergies No known allergies.

Physical Exam

Pre-Procedure Physical Exam Abdominal exam: Normal. Airway exam: Normal. Cardiopulmonary exam: Normal. Extremity exam: Normal.
Comments on Physical Exam Abd: Soft, NT/ND.

Preprocedure

Patient Admission Status Inpatient with endoscopy performed in the Endoscopy suite.

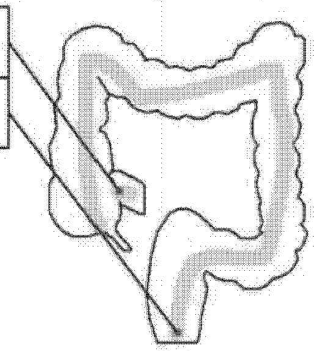
Sedation / Anesthesia

Presedation Assessment ASA classification: III. Urgency: Elective. Assessed by Anesthesiologist.
Monitoring The patient was monitored by: blood pressure measurements, ECG, pulse oximetry, capnography.
Medications Level of sedation: Moderate (conscious sedation). Sedation was managed by: Endoscopist (Attending physician). Sedation medication(s) administered: fentanyl 50 mcg IV, midazolam 4 mg IV.

Colonoscopy Findings

NORMAL EXAMINATION: Starting location: Terminal ileum. Ending location: Terminal ileum. Image(s) taken.

DIVERTICULOSIS: Starting location: Rectum. Ending location: Cecum. Degree moderate Image(s) taken.



Assessment

Assessment

MR ENDO

* Final *

PENNSTATE
The Milton S. Hershey Medical Center
The College of Medicine

Name: Vargas, Justino
Birthdate: Redacted
Patient ID: 2318020

Procedure Report **Colonoscopy Report**
Date: 12/2/2014 Time: 2:30 PM

1. Moderate to severe diverticulosis
2. Normal colon othewise
3. Normal terminal ileum
4. Brown stool throughout the colon

PLAN:
1. Further management as per inpatient team

Events / Interventions

Unplanned Events There were no unplanned events or interventions.

Report electronically signed by: Emmanuelle Williams 12/2/2014 5:36:00 PM

MR ENDO